Cervical Cancer Screening Guidelines (pg. 1)

	American Cancer Society (ACS)[1,2] 2002	U.S. Preventive Services Task Force (USPSTF)[3] 2003	American College of Obstetricians and Gynecologists (ACOG)[4] 2009
When to start screening	Approximately 3 years after onset of vaginal intercourse, but no later than age 21.^	Within 3 years of onset of sexual activity or age 21, whichever comes first. *(A recommendation)*	Age 21 regardless of the age of onset of sexual activity. Should be avoided before age 21. *(Level A evidence)*
Screening method & intervals			
Conventional cytology	Annually; every 2–3 years for women age ≥ 30 years with a history of 3 negative cytology tests.* Sexual history should not be used as a rationale for more frequent screening.	At least every 3 years *(A recommendation)*	Every 2 years from age 21–29 years *(Level A evidence)*; every 3 years for women age ≥ 30 years with a history of 3 negative cytology tests.* *(Level A evidence)*
Liquid-based cytology	Every 2 years; every 2–3 years for women age ≥ 30 years with a history of 3 negative cytology tests.* Sexual history should not be used as a rationale for more frequent screening.	Insufficient evidence *(I recommendation)*	Every 2 years from age 21–29 years *(Level A evidence)*; every 3 years for women age ≥ 30 years with a history of 3 negative cytology tests.* *(Level A evidence)*
HPV co-test (cytology + HPV test)	Not recommend under age 30. Age ≥ 30 years, no more than every 3 years if HPV negative, cytology normal. Sexual history should not be used as a rationale for more frequent screening.	Insufficient evidence *(I recommendation)*	Age ≥ 30 years, no more than every 3 years if HPV negative, cytology normal *(Level A evidence),* even with new sexual partners. Not recommended for women younger than 30 years.
Primary HPV testing§	Not FDA approved	Not FDA approved	Not FDA approved
When to stop screening	Women age ≥ 70 years with ≥ 3 recent, consecutive negative tests and no abnormal tests in prior 10 years.* At risk women* should continue screening as long as they are in reasonable health.	Women age > 65 years with adequate recent screening with normal Pap tests, who are not otherwise at high risk for cervical cancer. *(D recommendation)*	Between age 65–70 years with 3 consecutive normal cytology tests and no abnormal tests in the past 10 years *(Level B evidence)*; an older woman who is sexually active and has multiple partners should continue to have routine screening.
Screening post-total hysterectomy	If removal for benign disease and no history of high-grade CIN or worse, may discontinue screening. Women with an undocumented history should be screened until 3 consecutive normal tests, and no abnormal tests within a 10-year period are achieved.	Discontinue if removal for benign disease. *(D recommendation)*	If removal for benign disease and no history of high-grade CIN or worse, may discontinue screening. *(Level A evidence)* Women for whom a negative history cannot be documented should continue to be screened. *(Level B evidence)*
The need for a pelvic exam	The ACS and others should educate women, particularly teens and young women, that a pelvic exam does not equate to a cytology test and that women who may not need a cytology test still need regular health care visits including gynecologic care. Women should discuss the need for pelvic exams with their providers.	Not addressed	Physicians should inform their patients that annual gynecologic examinations may be appropriate. *(Level C evidence)*‡
Screening among those immunized against HPV 16/18	It is critical that women, whether vaccinated or not, continue screening according to current ACS early detection guidelines.	Not addressed	Recommendations remain the same regardless of vaccination status. *(Level C evidence)*

[1] Saslow D, et al. American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer. *CA Cancer J Clin* 2002; 52: 342-362.; [2.] D. Saslow et.al. American Cancer Society guideline for HPV vaccine use to prevent cervical cancer and its precursors. *CA Cancer J Clin* 2007 Jan-Feb;57(1):7–28.

[3] USPSTF. Screening for Cervical Cancer. Jan 2003. Available at: http://www.ahrq.gov/clinic/3rduspstf/cervcan/cervcanrr.pdf.

[4] ACOG Practice Bulletin no. 109: Cervical cytology screening. ACOG Committee on Practice Bulletins-Gynecology. *Obstet Gynecol.* 2009 Dec;114(6):1409–20.

^ Provider discretion and patient choice should be used to guide initiation of screening in women aged 21 years and older who have never had vaginal intercourse and for whom the absence of a history of sexual abuse is certain.

* Some exceptions apply (e.g., women who are immunocompromised, have a history of prenatal exposure to DES, HIV positive, women previously treated for CIN 2 or 3, or cancer etc.).

CIN = cervical intraepithelial neoplasia

§ Primary HPV testing is defined as conducting the HPV test as the first screening test. It may be followed by other tests (like a Pap) for triage.

‡ More specific guidance from 2003 states an annual pelvic examination is a routine part of preventive care for all women age ≥ 21 years even if they do not need cervical cytology screening. (Level C evidence)

Cervical Cancer Screening Guidelines (pg. 2)

	American Cancer Society (ACS)	U.S. Preventive Services Task Force (USPSTF)	American College of Obstetricians and Gynecologists (ACOG)
Guideline committee	ACS-convened expert panel	Federally-appointed panel of independent experts	ACOG Committee on Practice Bulletins-Gynecology
Methods used to analyze the evidence	Panel is divided into working groups to develop the recommendations after review of existing guidelines. Panel members review articles using specific criteria.	The panel reviews the evidence, estimates the magnitude of benefits and harms, reaches consensus about the net benefit for each preventive service, and issues a recommendation.	Review of published meta-analyses and systematic review. Analysis of available evidence. When reliable research not available, consulted with experts.
Methods used to formulate recommendations	Consensus-driven	Consensus-driven	Not stated
Definitions of level of recommendation or evidence assigned	Not applicable	*A recommendation:* The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.§ *B recommendation*: The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.§ *C recommendation*: The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.§ *D recommendation*: The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.§ *I recommendation*: The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that the [service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.§	*Level A evidence*: recommendations are based on good and consistent scientific evidence. *Level B evidence*: recommendations are based on limited or inconsistent scientific evidence. *Level C evidence*: based primarily on consensus and expert opinion.
Source of funding	American Cancer Society	United States Government	American College of Obstetricians and Gynecologists
Disclosures of conflict	Provided	Not stated. Disclaimer: The USPSTF has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.	Not stated
Reference	National Guideline Clearinghouse, available at: www.guidelines.gov. Saslow D, et al. American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer. *CA Cancer J Clin* 2002; 52:342–362.¥	National Guideline Clearinghouse, available at: www.guidelines.gov. USPSTF Screening for Cervical Cancer, Jan 2003. Available at: http://www.ahrq.gov/clinic/3rduspstf/cervcan/cervcanrr.pdf.¥	National Guideline Clearinghouse, available at: www.guidelines.gov. ACOG Practice Bulletin no. 109: Cervical cytology screening. ACOG Committee on Practice Bulletins-Gynecology. *Obstet Gynecol*. 2009 Dec;114(6):1409–20.

§These are the USPSTF grade definitions used to determine the recommendations for the 2003 guidelines. However, the grade definitions were revised in 2007.

¥The National Guideline Clearinghouse is a comprehensive database of evidence-based clinical practice guidelines and provides an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines. The database only maintains guidelines recommended in the previous 5 years, so the ACS and USPSTF guidelines are no longer accessible.